| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z 000 | Initial Comments<br><br>This Statement of Deficiencies was generated as the result of four complaint investigations under State licensure conducted at your facility on 4/9/09 and finalized on 4/21/09.<br><br>The survey was conducted using Nevada Administrative Code (NAC) 449, Skilled Nursing Facilities Regulations.<br><br>Complaint #NV00021294 was unsubstantiated with unrelated deficiencies cited. (see Tags 400, 427)<br><br>Complaint #NV00021305 was substantiated with deficiencies cited. (see Tags 063, 310)<br><br>Complaint #NV00021508 was substantiated with deficiencies cited. (see Tags 230, 310)<br><br>Complaint #NV00021544 was substantiated with no deficiencies cited.<br><br>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. | Z 000 | | |
| Z 63 SS=D | NAC 449.74429 Transfer or Discharge of Patient<br><br>4. Upon admission of a patient to a facility for skilled nursing and at the time the facility transfers the patient for hospitalization or therapeutic leave, the facility shall provide to the patient and to the legal representative of the patient or to a member of the patient's family, in writing:<br>(a) The time within which the patient may resume | Z 63 | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z 63 | Continued From page 1<br>his residency in the facility without waiting for readmission and<br>(b) The policy of the facility for readmitting a patient whose hospitalization or therapeutic leave exceeds the time within which he may resume his residency in the facility without waiting for readmission upon the first availability of a bed in a semiprivate room.<br><br>This Regulation is not met as evidenced by:<br>Based on record review, interview, and policy review the facility failed to ensure that a resident and his legal representative were notified that the facility would not allow the resident to return after an elective surgical procedure for 1 of 7 sampled residents. (#1)<br><br>Findings include:<br><br>Resident # 1 was admitted to the facility on 11/10/08, with diagnoses including ulcerations of the lower extremities, protein calorie malnutrition, depression, and Methicillin resistant staphylococcus aureus (MRSA) infection of lower extremity wounds.<br><br>Record review revealed that Resident #1 was transferred to an acute care facility on 2/10/09, for an elective surgical procedure. The resident was to be discharged from the acute care facility on 3/17/09, back to the facility.<br><br>Resident #1's son was interviewed on 4/9/09 at 12:35 PM, and he reported that he had visited the facility on a regular basis to fix up the resident's room and to take things home to be washed. He reported that he had been in the facility numerous times and had never been told that the resident would not be allowed to return to the facility. The | Z 63 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z 63 | Continued From page 2<br><br>resident's son further reported that he had called the facility on 3/16/09, to notify the director of nurses (DON) that the resident would be returning to the facility the following day. The DON reportedly stated the "she would see him (the resident) when he got to the facility." The resident's son also reported that he found out that his father would not be able to return to the facility from the discharge planner at the acute care facility on the day of discharge. He reported that he was not given any notice or any opportunity to appeal this decision.<br><br>On 4/9/09 at 11:20 AM, the DON was interviewed and reported that she did not know that Resident #1 was not to return to the facility. She reported that she did tell the resident's son that she would be happy to see him the next day when he returned.<br><br>On 4/9/09 at 12:20 PM, the administrator was interviewed and reported that the reason that the facility refused to accept Resident #1 back to the facility was that his pay source was Medicaid. He reported that the number of Medicaid residents in the facility was high at the time, and he was directed by the corporate representative to decrease the number of Medicaid cases. One of the ways he accomplished this was to disallow Medicaid patients that are transferred to other facilities to return. He further reported that the facility did not give the resident nor his family any notice, or opportunity to appeal the decision to disallow the resident to be admitted back to the facility.<br><br>Severity: 2 Scope: 1 | Z 63 | | |
| Z230 SS=K | NAC 449.74469 Standards of Care | Z230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z230 | Continued From page 3<br>A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the patient's highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care developed pursuant to NAC 449.74439.<br><br>This Regulation is not met as evidenced by:<br>Based on record review, interview, review of the facility's policies and procedures and industry standards the facility failed to follow its' policies and procedures and industry standards related to peritoneal dialysis for 2 of 7 sampled residents. (#2, #3)<br><br>Findings include:<br><br>Resident #2 was admitted to the facility on 1/15/09, with diagnoses including end stage renal disease, failure to thrive, coronary atherosclerosis, congestive heart failure, atrial fibrillation, anemia, and hypothyroidism. The resident's legal representative had been performing peritoneal dialysis for the resident in the community for six years, without the resident contracting an infection.<br><br>Record review revealed a Minimum Data Set resident assessment for Resident #2: Section B., 4. Cognitive skills for daily decision making, dated 1/22/09, that showed that the resident had been independent in decision making with "decisions being consistent/reasonable."<br><br>Record review revealed a weekly nursing summary dated 1/22/09, with the following boxes checked: Alert, memory recall - current season, | Z230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z230 | Continued From page 4 | Z230 | | |

staff names/faces, that he is in a nursing home; decision making - independent. A weekly nursing summary dated 1/28/09, read: Alert, memory recall - staff names/ faces, that he is in a nursing home; decision making - independent.

Record review revealed a physician's progress note dated 1/19/09 that read: "Abdomen: normal, peritoneal catheter."

Record review revealed that Resident #2 had been transferred to an acute care facility on 3/7/09, for coughing and hypoxia.

On 4/6/09 at 10:30 AM, Resident #2's son in law was interviewed and reported that a nurse from the facility contacted him on 3/6/09 at 8:00 AM, to notify him that the resident was coughing and refusing to take his medications. The son in law reported that the resident had become progressively worse overnight, with an oxygen saturation of 74% and the nurse had called again in the morning on 3/7/09. He reported that the nurse had stated to him that the resident's condition had deteriorated and that the nurse had asked him if he would like her to send him to the hospital. The resident's son in law then reported that he directed the nurse to call the nephrologist that follows the resident for treatment of his renal failure. He then reported that the nurse was not aware that the resident had a nephrologist involved with the resident's care. The nurse then agreed to call the nephrologist. The resident's son in law further reported that the nurse called him to report that she was directed by the nephrologist to send the resident to an acute care facility emergency department. The nurse then reportedly called a dialysis nurse consultant to determine whether or not to send the resident to the hospital. The resident's son in law reported

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z230 | Continued From page 5<br><br>that the nurse then called back to ask what hospital to send the resident to, and the son in law reported that he told her to send the resident to the closest hospital. The resident reportedly passed away on 3/11/09. Record review revealed a death certificate that reported that the resident had expired and that the cause of death was peritonitis.<br><br>Review of Resident #2's medical record revealed entries made into the nurse's notes that contained the following:<br>2/25/09 - the psychiatrist did a consult with the resident and documented that the resident was "underhydrated?"<br>2/26/09 - "Patient continues to not eat takes some fluids... Increased apical rate, abdominal distension..."<br>2/27/09 - "the resident had an elevated temperature"<br>3/6/09 - "Resident agitated; resident coughing, chest x-ray ordered to rule out pneumonia; weight loss 31 pounds"<br>3/7/09 - "Resident agitated, yelling for help; alert and oriented to self, skin pale; breathing labored and oxygen saturation 74%; skin ash color with labored breathing; sent to emergency room for evaluation."<br><br>No evidence was found that the nursing staff had contacted the physician related to a change in Resident #2's condition prior to 3/7/09. No evidence was found that the resident's primary physician had been aware of the psychiatrist's impression on 2/25/09.<br><br>Record review revealed a care plan for Resident #2 that was developed for outpatient dialysis therapy. The care plan revealed the following:<br>Goals: will not experience complications | Z230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z230 | Continued From page 6<br>secondary to dialysis for 90 days.<br>Approach:<br>1. Resident will be transported to dialysis center on treatment days.<br>2. Resident will be provided with take out meals if not in the facility at mealtimes.<br>3. Avoid taking blood pressures or giving injections over shunted arm.<br>5. After dialysis treatment observe resident for adverse reactions to treatment.<br><br>Record review revealed that Resident #2 had no shunt, was not transported out, as his peritoneal dialysis was performed at the facility<br><br>Resident #3 was admitted to the facility on 3/18/09, with diagnoses including end-stage renal disease requiring peritoneal dialysis, diabetes mellitus and peripheral vascular disease. The resident was dependent for all peritoneal dialysis needs.<br><br>Record review revealed a document titled "Nursing Assessment" that was completed upon Resident #3's admission on 3/18/09 that read:<br>Section 3. Vital Signs: temperature - 98.0 Fahrenheit<br>Section 8. Physical Assessment:<br>A. Neuro/Cognitive: independent in decision making with "decisions being consistent/reasonable."<br>E. Pain: denies pain on admission<br>J. Gastrointestinal: no problems documented<br><br>Record review revealed that Resident #3 had been transferred to an acute care facility on 4/4/09, with a temperature of 100.3 Fahrenheit.<br><br>Record review revealed the following nurse's notes entries: | Z230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z230 | Continued From page 7<br><br>3/23/09 - "Has disorientation at times."<br>3/24/09 - "Resident very needy, on the call light every 10 minutes."<br>3/25/09 - "Keeps on moaning, complains of shoulder pain."<br>3/28/09 - "Medicated for pain in left shoulder."<br>3/31/09 - "Resident difficult today. Not compliant. Found medications in his bed. Restless early shift. Calling for help constantly. Dialysis machine keeps beeping."<br><br>Record review revealed the following:<br>3/24/09 night shift: temperature - 99.4 Fahrenheit<br>3/26/09 night shift: temperature - 99.1 Fahrenheit<br>4/4/09 night shift: temperature - 99.1 Fahrenheit<br><br>Record review revealed the following entries into the physical therapy weekly summary:<br>3/20/09 - 3/26/09: "Patient has been ill intermittently...but puts effort towards his exercises ... throughout the day and tries his best without trying to regurgitate onto his caregivers."<br>3/27/09 - 4/2/09: "Actively participated in three of five treatments due to ... bilateral shoulder pain."<br><br>Record review revealed no evidence that the physician had been made aware of Resident #3's condition changes prior to the day that the resident was transferred to the acute care facility.<br><br>The DON was interviewed on 4/9/09 at 11:20 AM, and reported that signs and symptoms to look for that may be indicative of peritonitis include: Distension or tenderness of the abdomen, nausea or vomiting, diarrhea, shoulder pain, elevated temperature, anxiety, change in level of consciousness, confusion, or draining of cloudy dialysate.<br><br>Record review of a physician's progress note | Z230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z230 | Continued From page 8<br>dated 3/26/09, revealed: "had vomiting after therapy."<br><br>The DON was interviewed on 4/9/09 at 11:20 AM, and reported that Resident #3 had been admitted to the acute care facility on 4/4/09, with a diagnosis of peritonitis.<br><br>Review of Resident #3's acute care record revealed that on 4/5/09, the emergency department physician recorded:<br>Assessment:<br>1. Sepsis, source peritonitis versus health care associated pneumonia.<br>Emergency Department Course:<br>White blood cell count 14,000. X-ray was clear for pneumonia.<br><br>Record review revealed that Resident #3 was still an inpatient at the acute care facility on 4/20/09.<br><br>The Staff Development Coordinator was interviewed on 4/9/09 at 11:00 AM, and reported that almost all of the registered nurses (RN'S) had completed training related to peritoneal dialysis. She reported that the facility had a consultant from a local dialysis center come in and train the facility staff related to peritoneal dialysis.<br><br>Review of the dialysis consultant's training outline revealed that he recommended that staff not wear gloves throughout the peritoneal dialysis procedures.<br><br>On 4/9/09 at 11:40 AM, the dialysis consultant was interviewed, and reported that he does recommend that staff not wear gloves during the peritoneal dialysis procedures because the powder in the gloves is a common source of | Z230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z230 | Continued From page 9<br>peritonitis. When asked if the procedures are to be performed using aseptic technique, he replied "no, it is a clean procedure."<br><br>The DON reported that she performs the peritoneal dialysis procedures on week-days. She reported that she does not wear gloves while performing peritoneal dialysis procedures.<br><br>The Staff Development Coordinator was interviewed and reported that the nurses were instructed not to wear gloves because the powder inside of the gloves is a common cause of peritonitis.<br><br>Record review revealed no evidence that staff were wearing gloves while performing peritoneal dialysis procedures.<br><br>Review of the facility's policies and procedures revealed a policy and procedure titled: Nursing Standards of practice, Subject: Dialysis, Peritoneal (CAPD)<br>Standard:<br><br>1. The qualified nursing staff will provide care as ordered by a physician for patients/residents requiring peritoneal dialysis that allows them to maintain their highest practicable level of function and health.<br>2. The qualified nursing staff will follow the (corporate) guidelines.<br>3. The health care center will obtain the "Resident Acknowledgement of "Informed Consent Form"#FFNP006<br>4. Refer to the Staff Development Standards of Practice: #24 "Competency for Peritoneal Dialysis."<br><br>Description: | Z230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z230 | Continued From page 10<br><br>Infection control practices and technique are essential to prevent the occurrence of peritonitis which often may prevent patients/residents from continuing to use peritoneal dialysis as a treatment modality.<br><br>Staff who provide care must receive specialized training so they possess advanced skill levels before providing peritoneal dialysis.<br>Equipment:<br><br>C. sterile and non-sterile gloves<br><br>Practice Guidelines:<br>5. Assess<br>A. Weight: Baseline is needed to determine fluid to be removed.<br><br>Dialysis Exchange:<br>C. Wash hands, don mask and non-sterile gloves. Both licensed nurse and patient/resident mask.<br>N. Don sterile gloves.<br><br>Review of a peer review article published by the Mid-Atlantic Renal Coalition titled: Preventing Bacterial Infections and Antimicrobial Resistance in Dialysis Patients, revealed the following:<br>Strategy 4: Prevention<br>-The Centers for Disease Control and Prevention (CDC) recommends wearing gloves at all times when touching patients or dialysis equipment to prevent infections by contaminants too small to be seen with the naked eye.<br><br>Severity: 4 Scope: 2 | Z230 | | |
| Z290 SS=H | NAC 449.74487 Nutritional Health; Hydration<br><br>1. Based on the comprehensive assessment of a | Z290 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z290 | Continued From page 11<br>patient conducted pursuant to NAC 449.74433, a facility for skilled nursing shall ensure that:<br>(a) The nutritional health of the patient is maintained, including, without limitation, the maintenance of his weight and levels of protein, unless the nutritional health of the patient cannot be maintained because of his medical condition.<br>(b) The patient receives a therapeutic diet if such a diet is required by the patient.<br>This Regulation is not met as evidenced by:<br>Based on record review, interview, policy review, and review of industry standards the facility failed to ensure adequate interventions to prevent a significant weight loss for 2 of 7 sampled residents. (#1, #2)<br><br>Findings include:<br><br>Resident #1 was admitted to the facility on 11/10/08, with diagnoses including ulcerations of the lower extremities, protein calorie malnutrition, depression, and Methicillin resistant staphylococcus aureus (MRSA) infection of lower extremity wound.<br><br>Record review revealed that Resident #1 was 73 inches in height.<br><br>Record review revealed that Resident #1's weight was checked on the following dates:<br>11/10/08 (admission): 192 pounds<br>11/11/09: 193 pounds<br>11/12/08: 193 pounds<br>11/19/08: 192 pounds<br>12/11/08: 133 pounds<br>12/17/08: 133 pounds<br>12/24/08: 138 pounds<br>1/1/09: 146 pounds<br>1/8/09: 138 pounds<br>1/21/09: 137 pounds | Z290 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z290 | Continued From page 12<br>2/1/09: 140 pounds<br><br>Record review revealed a care plan for Resident #1 that was not dated. It listed a goal of "weight will stabilize at 190 pounds." Interventions included: "4 ounces of house supplement three times daily between meals, encourage intake of meals and offer alternate if (intake) less than 75%, offer snacks per protocol, ice cream with lunch and dinner, report weight change to physician, dietician, and family."<br><br>The dietician was interviewed on 4/9/09 at 11:30 AM, and reported that Resident #1 had stated to her that he wanted to be at or around 190 pounds. She further reported that she did not get aggressive with the resident's nutritional care because she felt that the scale must have been inaccurate. She reported that she did not recommend that the scale be checked or calibrated.<br><br>Resident #2 was admitted to the facility on 1/15/09 with diagnoses including end stage renal disease, failure to thrive, coronary atherosclerosis, congestive heart failure, atrial fibrillation, anemia, and hypothyroidism. The resident's legal representative had been performing peritoneal dialysis for the resident in the community for six years.<br><br>Record review revealed that Resident #2 was 68 inches in height.<br><br>Record review revealed that Resident #2's weight was checked on the following dates:<br>1/16/09: 193 pounds<br>1/17/09: 190 pounds<br>1/18/09: 188 pounds<br>1/21/09: 189 pounds | Z290 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z290 | Continued From page 13<br>1/23/09: 186 pounds<br>1/24/09: 182 pounds<br>1/25/09: 187 pounds<br>1/26/09: 185 pounds<br>1/27/09: 183 pounds<br>2/1/09: 181 pounds<br>2/2/08: 180.6 pounds<br>2/3/09: 173 pounds<br>2/4/09: 176 pounds<br>2/5/09: 177 pounds<br>2/6/09: 178 pounds<br>2/7/09: 175 pounds<br>2/11/09: 167 pounds<br>2/18/09: 168.3 pounds<br><br>Record review of an entry into the nurse's note dated 3/6/09 revealed: "Resident's weight 159 weight loss of 31 pounds."<br><br>2/25/09 - The psychiatrist did a consult with Resident #2 and documented that the resident was "underhydrated?" No evidence was found that the resident's primary physician had been aware of the psychiatrist's impression.<br><br>Resident #2's legal representative was interviewed and reported that the resident did not have large weight fluctuations prior to admission to the facility. He reported that the resident's weight was checked frequently at home due to his renal failure.<br><br>The dietician was interviewed on 4/9/09 at 11:30 AM, and reported that she was aware that Resident #2 had been losing weight and that she had completed a dietary consult for the resident. She reported that she did not write any information on Resident #2's medical record, but that she routinely writes updates on the initial dietary evaluation record. She reported that she | Z290 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z290 | Continued From page 14<br>"must have missed this one."<br><br>Review of the facility's nutrition policies and procedures revealed the following policy:<br>Subject: Referrals to the Registered Dietician<br>Procedures:<br>6. At his or her next facility visit, facility's registered dietician (RD) will (a) complete the nutritional assessment or (b) document his her agreement with the Nutrition Services Director's review of the patient/resident status and indicate additional recommendations as appropriate.<br><br>Review of "The Renal Network, Inc., Delivery of Dialysis Care Within the Long Term Care Facility, End Stage Renal Disease Special Study, dated 6/30/06 revealed the following industry standards:<br>(Page 15) 4.4: "The Technical Expert Panel recommended the initial comprehensive assessment be completed within two weeks of admission to the unit, and reassessment every month thereafter due to the short length of stay of many patients and their high level of acuity."<br><br>Review of Nutrition and Diagnosis Related Care, Lippincott Sixth Edition, Copyright 2008, revealed the following industry standards:<br><br>Table 16-13 Role of the Dietitian in Care of Dialysis Patients<br>"Multiple diet parameters are necessary to provide optimal nutritional health, including monitoring of calories, protein, sodium, fluid, potassium, calcium, and phosphorus, as well as other individualized nutrients. Consider all modes of nutritional intervention; use that which is best accepted by the patient and the least invasive."<br><br>Peritoneal Dialysis<br>-"Fluid restrictions are not always needed with | Z290 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z290 | Continued From page 15<br>peritoneal dialysis. Patient should learn how to recognize significant changes in dry weight (adjusted edema-free body weight) or food intake. Discuss actions to be taken. Usually, three to four pounds between intermittent peritoneal dialysis is allowed.<br><br>Severity: 3 Scope: 2 | Z290 | | |
| Z310 SS=K | NAC449.74493 Notification of Changes or Condition<br><br>1. A facility for skilled nursing shall immediately notify a patient, the patient's legal representative or an interested member of the patient's family, if known, and, if appropriate, the patient's physician, when:<br>(a) The patient has been injured in an accident and may require treatment from a physician;<br>(b) The patient's physical, mental or psychosocial health has deteriorated and resulted in medical complications or is threatening the patient's life;<br>(c) There is a need to discontinue the current treatment of the patient because of adverse consequences caused by that treatment or to commence a new type of treatment;<br>(d) The patient will be transferred or discharged from the facility;<br>(e) The patient will be assigned to another room or assigned a new roommate; or<br>(f) There is any change in federal or state law that affects the rights of the patient.<br>This Regulation is not met as evidenced by:<br>Based on record review, interview, and policy review the facility failed to notify a resident and his legal representative that the facility would not allow the resident to return after an elective surgical procedure for 1 of 7 sampled residents (#1), and failed to notify the resident's physician of a change in condition, in a timely manner, for 2 | Z310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z310 | Continued From page 16<br>of 7 sampled residents. (#2, #3)<br><br>Findings include:<br><br>Resident #2 was admitted to the facility on 1/15/09, with diagnoses including end stage renal disease, failure to thrive, coronary atherosclerosis, congestive heart failure, atrial fibrillation, anemia, and hypothyroidism. The resident's legal representative had been performing peritoneal dialysis for the resident in the community for six years, without the resident contracting an infection.<br><br>Record review revealed a Minimum Data Set resident assessment for Resident #2: Section B., 4. Cognitive skills for daily decision making, dated 1/22/09, that showed that the resident had been independent in decision making with "decisions being consistent/reasonable."<br><br>Record review revealed a weekly nursing summary dated 1/22/09, with the following boxes checked: Alert, memory recall - current season, staff names/faces, that he is in a nursing home; decision making - independent. A weekly nursing summary dated 1/28/09, read: Alert, memory recall - staff names/ faces, that he is in a nursing home; decision making - independent.<br><br>Record review revealed a physician's progress note dated 1/19/09 that read: "Abdomen: normal, peritoneal catheter."<br><br>Record review revealed that Resident #2 had been transferred to an acute care facility on 3/7/09, for coughing and hypoxia.<br><br>On 4/6/09 at 10:30 AM, Resident #2's son in law was interviewed and reported that a nurse from | Z310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z310 | Continued From page 17<br><br>the facility contacted him on 3/6/09 at 8:00 AM, to notify him that the resident was coughing and refusing to take his medications. The son in law reported that the resident had become progressively worse overnight, with an oxygen saturation of 74% and the nurse had called again in the morning on 3/7/09. He reported that the nurse had stated to him that the resident's condition had deteriorated and that the nurse had asked him if he would like her to send him to the hospital. The resident's son in law then reported that he directed the nurse to call the nephrologist that follows the resident for treatment of his renal failure. He then reported that the nurse was not aware that the resident had a nephrologist involved with the resident's care. The nurse then agreed to call the nephrologist. The resident's son in law further reported that the nurse called him to report that she was directed by the nephrologist to send the resident to an acute care facility emergency department. The nurse then reportedly called a dialysis nurse consultant to determine whether or not to send the resident to the hospital. The resident's son in law reported that the nurse then called back to ask what hospital to send the resident to, and the son in law reported that he told her to send the resident to the closest hospital. The resident reportedly passed away on 3/11/09. Record review revealed a death certificate that reported that the resident had expired and that the cause of death was peritonitis.<br><br>Review of Resident #2's medical record revealed entries made into the nurse's notes that contained the following:<br>2/25/09 - the psychiatrist did a consult with the resident and documented that the resident was "underhydrated?"<br>2/26/09 - "Patient continues to not eat takes | Z310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z310 | Continued From page 18<br>some fluids... Increased apical rate, abdominal distension..."<br>2/27/09 - "the resident had an elevated temperature"<br>3/6/09 - "Resident agitated; resident coughing, chest x-ray ordered to rule out pneumonia; weight loss 31 pounds"<br>3/7/09 - "Resident agitated, yelling for help; alert and oriented to self, skin pale; breathing labored and oxygen saturation 74%; skin ash color with labored breathing; sent to emergency room for evaluation."<br><br>No evidence was found that the nursing staff had contacted the physician related to a change in Resident #2's condition prior to 3/7/09. No evidence was found that the resident's primary physician had been aware of the psychiatrist's impression on 2/25/09.<br><br>Record review revealed a care plan for Resident #2 that was developed for outpatient dialysis therapy. The care plan revealed the following:<br>Goals: will not experience complications secondary to dialysis for 90 days.<br>Approach:<br>1. Resident will be transported to dialysis center on treatment days.<br>2. Resident will be provided with take out meals if not in the facility at mealtimes.<br>3. Avoid taking blood pressures or giving injections over shunted arm.<br>5. After dialysis treatment observe resident for adverse reactions to treatment.<br><br>Record review revealed that Resident #2 had no shunt, was not transported out, as his peritoneal dialysis was performed at the facility<br><br>Resident #3 was admitted to the facility on | Z310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z310 | Continued From page 19<br><br>3/18/09, with diagnoses including end-stage renal disease requiring peritoneal dialysis, diabetes mellitus and peripheral vascular disease. The resident was dependent for all peritoneal dialysis needs.<br><br>Record review revealed a document titled "Nursing Assessment" that was completed upon Resident #3's admission on 3/18/09 that read:<br>Section 3. Vital Signs: temperature - 98.0 Fahrenheit<br>Section 8. Physical Assessment:<br>A. Neuro/Cognitive: independent in decision making with "decisions being consistent/reasonable."<br>E. Pain: denies pain on admission<br>J. Gastrointestinal: no problems documented<br><br>Record review revealed that Resident #3 had been transferred to an acute care facility on 4/4/09, with a temperature of 100.3 Fahrenheit.<br><br>Record review revealed the following nurse's notes entries:<br>3/23/09 - "Has disorientation at times."<br>3/24/09 - "Resident very needy, on the call light every 10 minutes."<br>3/25/09 - "Keeps on moaning, complains of shoulder pain."<br>3/28/09 - "Medicated for pain in left shoulder."<br>3/31/09 - "Resident difficult today. Not compliant. Found medications in his bed. Restless early shift. Calling for help constantly. Dialysis machine keeps beeping."<br><br>Record review revealed the following:<br>3/24/09 night shift: temperature - 99.4 Fahrenheit<br>3/26/09 night shift: temperature - 99.1 Fahrenheit<br>4/4/09 night shift: temperature - 99.1 Fahrenheit | Z310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z310 | Continued From page 20<br><br>Record review revealed the following entries into the physical therapy weekly summary:<br>3/20/09 - 3/26/09: "Patient has been ill intermittently...but puts effort towards his exercises ... throughout the day and tries his best without trying to regurgitate onto his caregivers."<br>3/27/09 - 4/2/09: "Actively participated in three of five treatments due to ... bilateral shoulder pain."<br><br>Record review revealed no evidence that the physician had been made aware of Resident #3's condition changes prior to the day that the resident was transferred to the acute care facility.<br><br>The DON was interviewed on 4/9/09 at 11:20 AM, and reported that signs and symptoms to look for that may be indicative of peritonitis include: Distension or tenderness of the abdomen, nausea or vomiting, diarrhea, shoulder pain, elevated temperature, anxiety, change in level of consciousness, confusion, or draining of cloudy dialysate.<br><br>Record review of a physician's progress note dated 3/26/09, revealed: "had vomiting after therapy."<br><br>The DON was interviewed on 4/9/09 at 11:20 AM, and reported that Resident #3 had been admitted to the acute care facility on 4/4/09, with a diagnosis of peritonitis.<br><br>Review of Resident #3's acute care record revealed that on 4/5/09, the emergency department physician recorded:<br>Assessment:<br>1. Sepsis, source peritonitis versus health care associated pneumonia.<br>Emergency Department Course:<br>White blood cell count 14,000. X-ray was clear | Z310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z310 | Continued From page 21<br>for pneumonia.<br><br>Record review revealed that Resident #3 was still an inpatient at the acute care facility on 4/20/09.<br><br>The Staff Development Coordinator was interviewed on 4/9/09 at 11:00 AM, and reported that almost all of the registered nurses (RN'S) had completed training related to peritoneal dialysis. She reported that the facility had a consultant from a local dialysis center come in and train the facility staff related to peritoneal dialysis.<br><br>Review of the dialysis consultant's training outline revealed that he recommended that staff not wear gloves throughout the peritoneal dialysis procedures.<br><br>On 4/9/09 at 11:40 AM, the dialysis consultant was interviewed, and reported that he does recommend that staff not wear gloves during the peritoneal dialysis procedures because the powder in the gloves is a common source of peritonitis. When asked if the procedures are to be performed using aseptic technique, he replied "no, it is a clean procedure."<br><br>The DON reported that she performs the peritoneal dialysis procedures on week-days. She reported that she does not wear gloves while performing peritoneal dialysis procedures.<br><br>The Staff Development Coordinator was interviewed and reported that the nurses were instructed not to wear gloves because the powder inside of the gloves is a common cause of peritonitis.<br><br>Record review revealed no evidence that staff | Z310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z310 | Continued From page 22<br>were wearing gloves while performing peritoneal dialysis procedures.<br><br>Review of the facility's policies and procedures revealed a policy and procedure titled: Nursing Standards of practice, Subject: Dialysis, Peritoneal (CAPD)<br>Standard:<br><br>1. The qualified nursing staff will provide care as ordered by a physician for patients/residents requiring peritoneal dialysis that allows them to maintain their highest practicable level of function and health.<br>2. The qualified nursing staff will follow the (corporate) guidelines.<br>3. The health care center will obtain the "Resident Acknowledgement of "Informed Consent Form"#FFNP006<br>4. Refer to the Staff Development Standards of Practice: #24 "Competency for Peritoneal Dialysis."<br><br>Description:<br>Infection control practices and technique are essential to prevent the occurrence of peritonitis which often may prevent patients/residents from continuing to use peritoneal dialysis as a treatment modality.<br><br>Staff who provide care must receive specialized training so they possess advanced skill levels before providing peritoneal dialysis.<br>Equipment:<br><br>C. sterile and non-sterile gloves<br><br>Practice Guidelines:<br>5. Assess | Z310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z310 | Continued From page 23<br><br>A. Weight: Baseline is needed to determine fluid to be removed.<br><br>Dialysis Exchange:<br>C. Wash hands, don mask and non-sterile gloves. Both licensed nurse and patient/resident mask.<br>N. Don sterile gloves.<br><br>Review of a peer review article published by the Mid-Atlantic Renal Coalition titled: Preventing Bacterial Infections and Antimicrobial Resistance in Dialysis Patients, revealed the following:<br>Strategy 4: Prevention<br>-The Centers for Disease Control and Prevention (CDC) recommends wearing gloves at all times when touching patients or dialysis equipment to prevent infections by contaminants too small to be seen with the naked eye.<br><br>Resident # 1 was admitted to the facility on 11/10/08, with diagnoses including ulcerations of the lower extremities, protein calorie malnutrition, depression, and Methicillin resistant staphylococcus aureus (MRSA) infection of lower extremity wounds.<br><br>Record review revealed that Resident #1 was transferred to an acute care facility on 2/10/09, for an elective surgical procedure. The resident was to be discharged from the acute care facility on 3/17/09, back to the facility.<br><br>Resident #1's son was interviewed on 4/9/09 at 12:35 PM, and he reported that he had visited the facility on a regular basis to fix up the resident's room and to take things home to be washed. He reported that he had been in the facility numerous times and had never been told that the resident would not be allowed to return to the facility. The | Z310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z310 | Continued From page 24<br><br>resident's son further reported that he had called the facility on 3/16/09, to notify the director of nurses (DON) that the resident would be returning to the facility the following day. The DON reportedly stated the "she would see him (the resident) when he got to the facility." The resident's son also reported that he found out that his father would not be able to return to the facility from the discharge planner at the acute care facility on the day of discharge. He reported that he was not given any notice or any opportunity to appeal this decision.<br><br>On 4/9/09 at 11:20 AM, the DON was interviewed and reported that she did not know that Resident #1 was not to return to the facility. She reported that she did tell the resident's son that she would be happy to see him the next day when he returned.<br><br>On 4/9/09 at 12:20 PM, the administrator was interviewed and reported that the reason that the facility refused to accept Resident #1 back to the facility was that his pay source was Medicaid. He reported that the number of Medicaid residents in the facility was high at the time, and he was directed by the corporate representative to decrease the number of Medicaid cases. One of the ways he accomplished this was to disallow Medicaid patients that are transferred to other facilities to return. He further reported that the facility did not give the resident nor his family any notice, or opportunity to appeal the decision to disallow the resident to be admitted back to the facility.<br><br>Severity: 4 Scope: 2 | Z310 | | |
| Z400 SS=D | NAC 449.74523 Social Services | Z400 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z400 | Continued From page 25<br><br>1. A facility for skilled nursing shall provide medically-related social services that are designed to assist the patients in the facility in enhancing or restoring their ability to function physically, socially and economically.<br>This Regulation is not met as evidenced by:<br>Based on record review and interview the facility failed to arrange for dental services in a timely manner for 1 of 7 sampled residents. (#4)<br><br>Findings include:<br><br>Resident #4 was admitted to the facility on 3/1/06, with diagnoses including cervicalgia, delirium, hypoxemia, anemia, vascular dementia, and renal artery atherosclerosis.<br><br>Record review revealed that the Resident #4's dentures had been found broken. No evidence was found as to how the dentures had been broken. An entry into the social service progress notes dated 3/11/09 read: "Staff informed me that they had found the resident's dentures. One half of the lower denture was found in a cup, and the other half was found in the drawer. My understanding is that the resident broke the denture herself, because no staff member had reported any incident with the resident's lower denture. The resident, due to her memory deficits has no specific explanation on her dentures." An entry made into the social services progress notes on 3/11/09, read: "The resident's husband came to my office and stated that we needed to do something about the resident's broken lower denture. I told him that I had been informed about the denture but we are not responsible for any item that we have not broke or damaged... An entry made into the social services progress notes on 3/12/09, read: "I had a call from the ombudsman and she reported that | Z400 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z400 | Continued From page 26<br><br>the resident's husband had contacted her about the resident's broken dentures. The ombudsman asked if we were going to pay for them? I explained that we did not damage the denture and our policy is paying only for items that we have damaged. Our staff did not break her denture from what has been noted by nursing."<br><br>Resident #4 's husband was interviewed on 4/13/09 at 8:30 AM, and reported that the facility had not made an appointment with a dentist to replace the broken denture. He reported that the resident had difficulty eating without both of her dentures. He further reported that the resident had been transferred to another facility and that she had not been seen by a dentist prior to leaving.<br><br>On 3/14/09 at 2:20 PM, the social worker was interviewed and reported that she did not make an appointment for Resident #4 to go to a dentist. She reported that the transport person had told her that the dentist that accepted the resident's insurance could not see her for about two or three months. The social worker reported that an appointment was not made partly because this was not seen as a dental emergency. She reported that she did not remember any interaction with the resident's husband.<br><br>Severity: 2 Scope: 1 | Z400 | | |
| Z427 SS=D | NAC 449.74529 Dental Services<br><br>A facility for skilled nursing shall:<br>3. Promptly refer a patient with lost or damaged dentures to a dentist.<br>This Regulation is not met as evidenced by:<br>Based on record review and interview the facility failed to arrange for dental services in a timely | Z427 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z427 | Continued From page 27<br>manner for 1 of 7 sampled residents. (#4)<br><br>Findings include:<br><br>Resident #4 was admitted to the facility on 3/1/06, with diagnoses including cervicalgia, delirium, hypoxemia, anemia, vascular dementia, and renal artery atherosclerosis.<br><br>Record review revealed that the Resident #4's dentures had been found broken. No evidence was found as to how the dentures had been broken. An entry into the social service progress notes dated 3/11/09 read: "Staff informed me that they had found the resident's dentures. One half of the lower denture was found in a cup, and the other half was found in the drawer. My understanding is that the resident broke the denture herself, because no staff member had reported any incident with the resident's lower denture. The resident, due to her memory deficits has no specific explanation on her dentures." An entry made into the social services progress notes on 3/11/09, read: "The resident's husband came to my office and stated that we needed to do something about the resident's broken lower denture. I told him that I had been informed about the denture but we are not responsible for any item that we have not broke or damaged... An entry made into the social services progress notes on 3/12/09, read: "I had a call from the ombudsman and she reported that the resident's husband had contacted her about the resident's broken dentures. The ombudsman asked if we were going to pay for them? I explained that we did not damage the denture and our policy is paying only for items that we have damaged. Our staff did not break her denture from what has been noted by nursing." | Z427 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVN556S | A. BUILDING _____ B. WING _____ | C 04/21/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTHSTONE OF NORTHERN NEVADA | 1950 BARING BLVD SPARKS, NV 89434 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z427 | Continued From page 28<br><br>Resident #4 's husband was interviewed on 4/13/09 at 8:30 AM, and reported that the facility had not made an appointment with a dentist to replace the broken denture. He reported that the resident had difficulty eating without both of her dentures. He further reported that the resident had been transferred to another facility and that she had not been seen by a dentist prior to leaving.<br><br>On 3/14/09 at 2:20 PM, the social worker was interviewed and reported that she did not make an appointment for Resident #4 to go to a dentist. She reported that the transport person had told her that the dentist that accepted the resident's insurance could not see her for about two or three months. The social worker reported that an appointment was not made partly because this was not seen as a dental emergency. She reported that she did not remember any interaction with the resident's husband.<br><br>Severity: 2 Scope: 1 | Z427 | | |